

E M P L O Y E	SSN: _____ Date of Birth: _____ Gender: M <input type="radio"/> F <input type="radio"/> Dependents: _____ Name: (Last) _____ (First) _____ (Middle initial) _____ Mailing Address: _____ City: _____ State: _____ Zip: _____ Telephone No.: _____ Employee signature: (X) _____ Date _____	Education: <input type="checkbox"/> Less than High School <input type="checkbox"/> GED or High School <input type="checkbox"/> Beyond High School
I N J U R Y / T R E A T M E N T	Date of Injury: _____ Time of Injury: _____ a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> Fatality Date (if applicable): _____ County Where Injury Occurred _____ Was Safety Equipment Provided? Yes <input type="checkbox"/> or No <input type="checkbox"/> Time Work Day Began on Date of Injury: _____ a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> Was Safety Equipment Used? Yes <input type="checkbox"/> or No <input type="checkbox"/> Date Returned to Work (if applicable): _____ Did Injury Occur on Employer Premises? Yes <input type="checkbox"/> or No <input type="checkbox"/> Address or Location of Injury: _____ Description of Injury: _____ _____ Date Employer Notified of Injury: _____ Injury Reported to: _____ Witness: _____	(See Codes on Second Page) Body Part Injured _____ (If code 90, Multiple Injury, please specify body part codes for each body part injured.) _____ _____ Nature of Injury _____ Cause of Injury _____
	Type of Treatment (please check one) <input type="checkbox"/> No Treatment <input type="checkbox"/> On-Site Treatment <input type="checkbox"/> Clinic <input type="checkbox"/> Emergency Room <input type="checkbox"/> Hospitalization	If treatment sought, please specify provider of treatment: Doctor, Clinic or Hospital Name: _____ Mailing Address: _____ City: _____ State: _____ Zip: _____ Telephone No.: _____
EMPLOYER/EMPLOYMENT INFORMATION:		
Federal ID No.: _____ # Employees: _____ Employer Name (DBA): _____ Mailing Address: _____ City: _____ State: _____ Zip: _____ Telephone No.: _____ County Where Employer Located: _____ Employer signature: _____ Date _____		Employment Type: <input type="checkbox"/> Regular or <input type="checkbox"/> Temporary Emp. Status: <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Seasonal <input type="checkbox"/> Volunteer Date Employee Hired: _____ Employee's Position: _____ Employee's Time in Current Position: _____ Employee's Hours Per Week: _____ Employee's Current Wage: \$ _____ per _____
CLAIM OFFICE INFORMATION		
NAICS for Employer Being Insured (Nature of Business): _____ Carrier Code _____ FEIN (Claim Office) <u>02-0449082</u> Claim Office <u>Technology Insurance Company</u> Claim Office Address <u>PO Box 5446</u> City <u>Cleveland</u> State <u>OH</u> ZipCode <u>44101-0446</u> Telephone _____ Email Address _____ Claim Office Claim # _____		<input type="checkbox"/> Check if Claim Office is same as Insurance Provider If not, you must complete the following UNDERLYING INSURANCE PROVIDER INFORMATION Carrier Code (If applicable) _____ FEIN (Insurance Provider) _____ Represented Entity Name _____ Address _____ City _____ State _____ Zip Code _____ Telephone Number _____ Policy Number <u>TARSD1018507-00</u> Effective Dates _____ Adjuster/Contact Person _____
Fax: <u>775-908-3724</u> Date Notified _____ Date to DOL _____		

DLR-LM-101 Revised 2/2017

DIVISION OF LABOR AND MANAGEMENT

Tel: 605.773.3681 dlr.sd.gov

FIRST REPORT OF INJURY

GENERAL INSTRUCTIONS

EMPLOYEE

1. Notify employer immediately of injury, as required by SDCL 62-7-10.
2. Complete all questions in the EMPLOYEE and INJURY/TREATMENT sections.
3. Sign the form.
4. Submit this form to your employer within three (3) business days after the injury.

EMPLOYER

1. Complete all questions in the EMPLOYER/EMPLOYMENT sections.
2. Sign the form.
3. Submit this form to your workers' compensation insurance carrier within seven (7) days of knowledge of the occurrence of the injury, as required by SDCL 62-6-2.
4. Give a copy of the form to the injured employee.
5. Keep the copy of the First Report of Injury for at least four (4) years from the date of injury, as required by SDCL 62-6-1.

BODY PART CODES

02 Blindness one eye	44 Chest, including ribs sternum, soft ribs	78 Ring finger at metacarpal bone
03 Blindness both eyes	48 Internal organs-other than heart, lungs	79 Ring finger at proximal joint
04 Deafness both ears	49 Heart	80 Ring finger at middle joint
05 Deafness one ear	51 Hip	81 Ring finger at distal joint
10 Multiple head injury	52 Upper leg	82 Little finger at metacarpal bone
11 Skull	53 Knee	83 Little finger at proximal joint
12 Brain	54 Lower leg	84 Little finger at middle joint
13 Ear(s)	55 Ankle	85 Little finger at distal joint
14 Eye(s)	56 Foot	86 Great toe metatarsal bone
17 Mouth	57 Toe (other than greater)	87 Great toe at proximal joint
19 Face (facial bones)	58 Toe (greater)	88 Great toe at distal joint
20 Multiple neck injury	60 Lungs	90 Multiple injury
21 Vertebrae	61 Groin	92 Other toe metatarsal bone
22 Disc	67 Thumb metacarpal bone	93 Other toe at proximal joint
24 Other	68 Thumb at proximal joint	94 Other toe at middle joint
31 Upper arm	69 Thumb at distal joint	95 Other toe at distal joint
32 Elbow	70 Index finger at metacarpal bone	96 Little toe metatarsal bone
33 Lower Arm-forearm	71 Index finger at proximal joint	97 Little toe at distal joint
34 Wrist	72 Index finger at middle joint	
35 Hand	73 Index finger at distal joint	
37 Thumb	74 Middle finger at metacarpal bone	
38 Shoulder	75 Middle finger at proximal joint	
41 Upper Back	76 Middle finger at middle joint	
42 Lower Back	77 Middle finger at distal joint	

Cause of Injury Codes

01 Body reaction/over reaction (includes chemicals)	70 Striking against or stepping on
03 Temperature extremes	78 Struck or injured by moving parts of machine
13 Caught in/under/between	81 Struck or injured, includes knife or sharp object, kicked, bit, etc. - struck by object, worker, patient, etc.
25 Fall from elevation	89 Hostile attack-person in act of crime
29 Fall from same level	90 Other than physical cause of injury
50 Motor vehicle	94 Repetitive motion - callous, blister, etc.
56 Bending/Lifting	97 Repetitive motion-carpal tunnel syndrome, etc.
65 Machinery/Equipment	99 Other

Nature of injury codes

00	Not applicable
01	Allergy
02	Disfigurement
71	Occupational disease
72	Hearing loss